FINAL REPORT TO THE GENERAL ASSEMBLY

ON

THE COMPREHENSIVE TREATMENT SERVICES PROGRAM (CTSP)

Senate Bill 1005 Section 21.60
Session Law 2001-424, Section 21.60

APRIL 2002

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES
and SUBSTANCE ABUSE SERVICES
CHILD and FAMILY SERVICES SECTION

DIVISION OF SOCIAL SERVICES

DEPARTMENT OF JUVENILE JUSTICE
AND DELINQUENCY PREVENTION

DEPARTMENT OF PUBLIC INSTRUCTION

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EXECUTIVE SUMMARY

The General Assembly of North Carolina, in the 2001 Session, passed legislation to establish the Comprehensive Treatment Services Program (CTSP) for children at risk for institutionalization or other out-of-home placements. The Department of Health and Human Services (DHHS) was charged with the implementation of the program in collaboration with the Division of Social Services (DSS), Department of Juvenile Justice and Delinquency Prevention (DJJDP), the Department of Public Instruction (DPI), the Administrative Office of the Courts (AOC) and other affected State agencies to provide appropriate and medically necessary residential and non-residential treatment alternatives for the target population. This document provides information on points specified in the final report mandated for submission on April 1, 2002.

- An infrastucture for Program implementation is now in existence.
  - Collaboratives have been established at the State, Regional, and Community levels.
  - Families are represented in State and Regional Collaboratives and in close to 90 percent of local community collaboratives.
  - Memoranda of Agreement have been signed among agencies at the State and local levels.

- Access to an array of medically necessary non-residential and residential services and providers have been and continue to be developed.

- More than 3,500 children have now been served in the program, *more than twice as many* have been identified and served through the Comprehensive Treatment Services Program than the 1660 children served in the former Willie M entitlement funding.

- In calendar year (CY) 2001, a total of 2,499 were screened, 2,170 of whom were found to be eligible. This represents more than a 400% increase in those children identified as eligible and served through CTSP.

- The number of children found to be eligible in CY 2001 alone is more than twice (216% increase) that of the cumulative total of 1, 660 children found to be eligible and served in CY 1999.

- *Forty-one percent (41 %) have been able to remain living at home* with utilization of the current array of nonresidential services: case management, case management support, community-based services (CBS), outpatient, respite services.

- Continuity of care for all eligible children is supported through case management and interagency planning with the family through each family's child and family team.

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- Reviews of the treatment plans of all children certified as eligible for the Willie M. Program prior to January 1998 and of all children whose annual cost for services was $100,000 were conducted and showed that:
  - The criteria for medical necessity were met.
  - Services were considered to be appropriate except in 12 percent of the cases reviewed where the child or caregiver refused or did not comply with services (10), the child was in a training school (7) or in detention facilities (7), the child was in need of Level III or IV out-of-home placement or PRTF or partial hospitalization (10); the child needed community-based services (6).
  - Children who had the most expensive services tended to be those with more complex diagnoses that were often compounded by co-occurring problems that were more deeply entrenched in childhood.
  - There were instances where children who had the most expensive services could have been served in less restrictive environments except that these children were without a family and did not have options other than residential care. With an appropriate array of interagency services and informal supports, these youth could be served in the community.
  - Diversions occurred in 42 percent of the cases. Approximately 16 percent (58) were diverted from training schools; 11 percent (40) from State Psychiatric institutions, and 7 percent (24) from DSS custody.

- There were only 53 children on the waitlist by the end of CY 2001, 21 of whom were waiting for Levels III and IV residential services

- A reduction in program expenditures occurred for children who had high utilization rates. The number of children with annual costs of $100,000 and more reduced from *225* in fiscal year 1998-1999 to *102* in fiscal year 2000-2001. The number of children with annual costs of $75,000-99,999 similarly declined from *202* in fiscal year 1998-1999 to *74* in fiscal year 2000-2001.

CHALLENGES AND RECOMMENDATIONS

Significant progress has been made in the implementation of the Comprehensive Treatment Services Program through a System of Care approach. Positive outcomes for children and families in NC have resulted in helping families help their children stay healthy, at home, in school and out of trouble. The system supporting child and family mental health services is dynamic, resilient and significant steps have been taken to align policy and practice across agencies at the state, regional and community levels. Increased access to residential treatment services have resulted from policy decisions that now must be balanced with creating capacity for treating more children and their families in their communities. A solid foundation for collaboration, communication, family involvement and evaluation is now established upon which to build future implementation. These are essential elements for continued progress and related state reform plan implementation.

INTRODUCTION

This report summarizes the progress achieved in implementation of the Comprehensive Treatment Services Program (CTSP) Senate Bill 1005 Section 21.60 (Session Law 2001-424, Section 21.60). Progress in achieving implementation of this legislation may be found in the sections that follow. Section I contains the historical context and progress of program implementation. Section II has descriptive data on the children and families served by the Program. Section III focuses on challenges faced by the Program and recommendations for the future. Provisions of the legislation are identified as they are addressed in the body of the text.

SECTION I
HISTORICAL CONTEXT AND PROGRESS OF PROGRAM IMPLEMENTATION

A SUMMARY OF THE TRANSITIONS FROM THE WILLIE M PROGRAM TO A STATEWIDE SYSTEM OF CARE APPROACH FOR CHILDREN ELIGIBLE FOR COMPREHENSIVE TREATMENT SERVICES PROGRAM (CTSP) AND THEIR FAMILIES

In July of 2000, the North Carolina Legislature created a new program for children with severe emotional disturbances. The "At Risk" Children's (ARC) Program was created with the goal of serving children at risk of institutionalization or other out of home placement. At the same time the ARC program was being created, the legislature also created another new program known as the Children's Residential Treatment Program with the goal of increasing the amount of funding available for residential treatment of children and adolescents with severe emotional disturbances, as an alternative to institutionalization (including inappropriate placement in Youth Development Centers (training schools), state hospitals, or families giving up custody of children to DSS to access behavioral health services). As a part of the same Legislative action these two new programs were created and the former Willie M. program was dissolved, eliminating the entitlement for services, the program's infrastructure and grievance procedures, with the intent of increasing services to a broader group of children than were served through the former Willie M. Program.

The General Assembly of North Carolina, in its 2001 Session, passed legislation to establish the Comprehensive Treatment Services Program (Senate Bill 1005, Section 21.60 -for children at risk for institutionalization or other out-of-home placements). The Department of Health and Human Services was charged with the implementation of the program in collaboration with the Division of Social Services, Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, the Administrative Office of the Courts and other affected State agencies to provide appropriate and medically necessary residential and non-residential treatment alternatives for the target population. This report is presented to describe the progress of the Program and respond to other provisions specified in the legislation.

PROGRESS IN MEETING PROGRAM OBJECTIVES

SECTION 21.60.(a)
OBJECTIVE 1 - Establish the Program for children at risk for institutionalization or other out of home placement. Implement in consultation with the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, the Administrative Office of the Courts and other affected State agencies.

Progress in Meeting Objective:
1.1 - The State Collaborative for Children and Families was established in January 2001 to ensure development of policies to promote statewide collaborative implementation of System of Care as the mechanism to address Section 21.60.(a) – (g) requirements. The State Collaborative is comprised of representatives of child-serving agencies, families, family advocates and other stakeholders. The NC Child Advocacy Institute hosts the meetings. The State Collaborative is co-chaired by Pat Solomon, a parent of a youth with serious emotional disturbance (SED) representing Families United and by Joel Rosch, Ph.D., (formerly with the Governor's Crime Commission) from the Duke University Child and Health Policy Initiative at the Center for Child and Family Policy. Over 30 organizations are represented among the 50 member participants. See Appendix A.

1.2 - A State Collaborative workgroup meets weekly to further define state-community, cross-agency and family inclusive processes for working with these children (target population) and their families in their communities.

- Question and Answer documents and other TA documents were developed and placed on the DHHS/DMH/Child and Family Services web page and disseminated statewide.
- Protocols/procedures including eligibility, screening, referral, assessment, service planning, role of Child and Family Teams and Community Collaboratives, funding issues, family support and involvement, access and other system challenges have been developed and disseminated.

1.3 - The State Collaborative serves as the stakeholder group for development of the DHHS State Plan, and as such, has worked together to develop all documents in the Plan related to children and youth with mental health and behavioral health needs, and their families. The State Plan fully integrates the population and intent of the CTSP Special Provision and describes full statewide implementation of a comprehensive System of Care. Five members of the State Collaborative participated on Secretary Hooker Odom's State Plan Advisory Committee.

1.4 - The Comprehensive Treatment Services Program (CTSP) for children at risk for institutionalization or other out of home placement was formally launched on March 1, 2001. The implementation of this new Program has been accomplished through a System of Care approach to treatment. As noted, "System of Care" is a philosophy of treatment that has gained nationwide acceptance as the Best Practice model in delivery of services to children with or at risk for serious emotional disturbances (SED) and their families. A System of Care (SOC) is a

comprehensive spectrum of mental health and other necessary services and supports, organized into a coordinated community network to meet multiple and changing needs of children with mental health needs and their families. Information on the SOC approach has been provided through a series of interagency regional and community-based training events statewide with periodic regional Program updates and technical assistance to local communities.

Prior to March 2001, in roll-out campaigns conducted regionally throughout the state, representatives from the Division of MH/DD/SAS, families of children with serious emotional disturbances, Area Programs, the Department of Social Services (DSS), the Department of Juvenile Justice and Delinquency Prevention (DJJDP), the Governor's Crime Commission, the DMA, DEI/E, DPH, DPI, AOC and other agencies shared the platform to describe the governance of the Program, its funding mechanisms and the strategies for its implementation.

1.5 - As required by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services Performance Agreement, Area Programs have submitted information regarding the implementation of Local Community Collaboratives. As of September 30, 2001, the 39 Area Programs had established a total of 60 local Community Collaboratives.

1.6 - The majority of Community Collaboratives have broad membership representing various community partners. At minimum, the collaborative membership includes representatives from local Area Mental Health Programs, DSS, DJJDP and DPI. A survey of these Community Collaboratives conducted by the Center for Urban Affairs and Community Services (CUACS) of North Carolina State University showed universal (100%) representation by Mental Health, DSS, Juvenile Justice and schools. Participation of family members or representatives from parent organizations was reported in a majority of community collaboratives (88%). Many collaboratives have representatives from Guardian ad litem (61%), private non-profit providers (57%), Public Health (48%), consumer advocacy organizations (46 %), faith-based organizations (30%) and private for-profit providers (28%). Some collaboratives have included membership from parks and recreation, university or college faculty, and local youth organizations and agencies, among others.

Barriers reported by collaboratives to including parents in meetings range from lack of respite care, transportation, time lost from work/meetings times and stipends for expertise and experience. It is anticipated that implementation of the non-Unit Cost Reimbursement (non-UCR) policy, intended to increase family participation, will enable communities to offer a variety of supports for family members and subsequently increase the number of Community Collaboratives that have *on-going* family participation.

Community Collaboratives complete needs assessments and facilitate community resource development and provider networks to meet the service and support needs for children eligible for CTSP funds. To date, Local Community Collaboratives have established a core membership, are meeting on a regular basis and have conducted initial community needs assessments.

1.7 - In addition to Community Collaboratives, Regional Collaboratives, staffed by Child and Family Services Regional Services Managers, have been established. Regional-level staff of DMH/DD/SAS, DPI, DSS, DJJDP, and AOC attends regional Collaboratives. The purpose of

this collaborative structure is to collate common local issues, note trends, provide consistent technical assistance and policy guidance to local level structures.

21.60.(a) OBJECTIVE 2 – Provide appropriate and medically necessary residential and nonresidential treatment alternatives for the target population. Funds shall target non-Medicaid children.

The target population includes children who are seriously emotionally disturbed (SED), have severe functional impairments, those in need of substance abuse services, and 'special populations' of children who are deaf or hard of hearing and/or those who are sexually aggressive. Eligibility criteria is based upon the foundation of strengths and needs known for these youth, including functional impairment in health, home, school and community, and the need for cross-agency care. The first priority has been to maximize existing and develop new resources to appropriately serve these children and youth (and their families) who have severe emotional or behavioral disturbances, are in or at risk for out of home placement (including, but not limited to state hospitals, foster care and Youth Development Centers), and need services from more than one agency.

A summary of the eligibility criteria for CTSP funds can be found in Appendix B.

Progress in Meeting Objective:

2.1 - Each eligible child and family has an individualized Child and Family Team (CFT) responsible for planning and delivery of services appropriate to meet the unique needs of the child and family. Compliance with medical necessity requirements for Medicaid and Non-Medicaid services is ensured through application of the NC Levels of Care for Children and Youth.

2.2 - In order to ensure that children who need services that are not funded by Medicaid receive them, several changes have been made to expand the menu of non-Medicaid service options, promote diversions from institutions, and bring rates up to better reflect costs:

- CTSP funds, restricted to 65% residential services and 35% nonresidential services in SFY 2000-2001, were 'decategorized' in SFY 2001-2002 allocations, i.e., funds were distributed in one funding category to allow maximum flexibility (i.e. many communities needs were not residential in nature and now are able to earn funds through nonresidential service provision) and promote nonresidential services in addressing individualized service needs for each eligible child/youth and family.
- Medicaid and Non-Medicaid rates are now the same.
- The respite rate has been increased to better reflect costs and provide incentives to engage providers in nonresidential service provision.
- Community Based Services (CBS) rates were increased to promote community-based alternatives to residential placements.
- Therapeutic leave has been added to promote transitions of youth to less restrictive levels of care.

- Assertive Community Treatment Teams (ACTT) have been added to the CTSP service array to help divert youth from unnecessary out of home placements and promote community-based service alternatives.
- Crisis services exist in some areas to provide a 'safety net' in/near the community for those who need acute crisis stabilization.

21.60.(a) OBJECTIVE 3 – Expand a system of care approach for services to children and their families statewide.

Progress in Meeting Objective:

3.1 - NC and National Evaluation data for System of Care (SOC) grant sites across the country are being utilized as the template to guide statewide SOC development. Four primary structural components are necessary to successfully implement a comprehensive SOC, now becoming operational across the State through the CTSP:

- Child and Family Teams - an integrated point of service in which all participants in the care for a child/youth and family work together as one team is the required method of service planning and delivery for all children/youth eligible for CTSP.
- Community Collaborative – An integrated point of program, policy and financial integration for local communities. Local Community Collaboratives (a requirement for CTSP funding) promote resource development/cost sharing and decrease cost shifting among agencies. Families and community stakeholders work together as a team to make decisions regarding how to meet the needs of their children and families in a comprehensive manner. A key goal of local Community Collaboratives is to ensure the successful implementation of their community's Child and Family Teams. Local Community Collaboratives act as the first step in resolving issues that the Child & Family Team cannot resolve, such as resource and provider network development.
- Regional Collaboratives – Previously, Regional staff of child-serving agencies were not working together and often did not know each other. A Regional Collaborative is now operational in each of the four regions of the State, and includes staff of DSS, DMH/DD/SAS, DJJDP, AOC, DPI, DPH, Deaf/Hard of Hearing, Health and other.
- The State Collaborative, as described in Objective 1, has expanded since January 2001 to include more than 30 child-serving agencies, private providers, pediatricians and other primary health care representatives, as well as family members. As a result of this expansion, progress in establishing more comprehensive approaches to care of children and families has accelerated:
  - A cross-agency service and funding grid has been drafted for dissemination to promote maximization of resources.
  - Communications regarding implementation of CTSP are disseminated at the same time to all local agency participants to promote consistent implementation. Whenever possible and relevant, joint communications across Divisions or Departments are sent to the communities to demonstrate state level uniformity and model similar collaborative working models locally. Examples of these include joint memos regarding behavioral screening (DSS and DMH), integration of service planning to meet educational requirements within county of residence (DPI and DHHS/DMH). See APPENDIX C

- Family members across the state have an increased presence through local and state representatives. NC Families United, a network of family members from counties across the State, recently received a three year federal Center for Mental Health Services Grant in support of statewide System of Care implementation.

21.60.(a) OBJECTIVE 4 – The Program shall include the following:

Progress in Meeting Objective:

4.1 - Behavioral Health Screenings – Behavioral health screening is operational for all children/youth in the target population through Area Programs, DSS, and DJJDP. Screening for children/youth in Local Education Agencies is in development now that DPI/LEAs are part of the Special Provision. The State Collaborative is compiling common assessment domains in effort to streamline and align screening and assessment protocols across agencies. DMH/DD/SAS, DPH and the NC Pediatric Society are working together to integrate a behavioral screening component in primary health care settings.

More than 3500 children served in the Comprehensive Services Treatment Program received an initial screening for emotional disturbance, cognitive impairment and substance abuse problems, based on the Diagnostic and Statistical Manual-Fourth Edition, and level of impaired functioning at home, in school, or in the community based on the Child and Adolescent Functional Assessment Scale. *Eligibility determination for CTSP services is a joint process* – the referring agency, the parent/caregiver, and the Area Program complete the assessment process as a team. Parents/caregivers of the eligible child receive a System of Care Parent Handbook explaining what they can expect from the service system and a packet of the assessment and other evaluation materials to increase their access to information and understanding of the service system.

4.2 - Appropriate and medically necessary services for deaf children - Eligibility protocols now highlight specification of children/youth who are deaf or hard of hearing (HOH). *The number of children/youth who are deaf has increased slightly during the past year, i.e., approximately .3% of total number of children eligible for CTSP for whom special population status was reported in CY 01*. More aggressive child find strategies for those children who are hard of hearing were implemented. In a survey conducted by Child and Family Services and the Coordinator for Deaf and Hard of Hearing with the Schools for the Deaf, as of December 31, 2001*, seventeen (17) youth who are hard of hearing were receiving mental health services. An additional 20 children were recently screened and met eligibility criteria for the Program.*

Regional staff of the Child and Family Services Section and the Regional Deaf and Hard of Hearing Coordinators meet regularly and are implementing an aggressive plan for inclusion of more youth in these services.

Access to and reimbursement for interpreter services is a critical component of a responsive system of care for these children. Mechanisms to address this gap are being examined as a part of the state reform. In addition, the Child and Family Services Section will be implementing recommendations from the Cultural Competence Strategic Plan (Cultural Competence Initiative Task Force, June 2000).

Progress is being made in developing additional resources for this population. The Coordinator for Deaf and Hard of Hearing is an active member of the State Collaborative and helped develop a recently released Request for Applications (utilizing part of the 3% set aside of CTSP funds at the state level for youth with complex needs) for targeted development of new resources for youth who are deaf or hard of hearing.

DHHS and DPI state officials met in October 2001 to assess the progress of Child and Family Team functioning for all eligible youth at the Schools for the Deaf, many of whom have already been identified as eligible for CTSP. Regional Deaf and Hard of Hearing Coordinators have received basic information on CTSP eligibility, SOC training. These Coordinators are working with their counterparts in Regional Collaboratives and are scheduled to receive more intensive SOC training in the coming months. A Child and Family Services staff member attends monthly meetings of the Deaf and HOH Coordinating Council.

4.3 - Appropriate and medically necessary services for sexually aggressive youth (SAY) - Eligibility protocol now highlights specification of children/youth who are sexually aggressive. *The number of children/youth served who have sexual disorders has increased from 2% (former Willie M. class members) to 12% for those for whom special population status was known and eligible for CTSP.* Progress is being made in developing additional resources for this population. A recently released Request for Applications (utilizing the 3% set aside of CTSP funds at the state level for youth with complex needs) targeted development of new residential and nonresidential resources for youth who are sexually aggressive to begin building additional service capacity. National experts in community-based 'safety-net' services for SAY provided intensive training at a statewide SOC conference in September 2001, with follow up technical assistance sessions planned.

4.4 - Appropriate and medically necessary services for youths needing substance abuse treatment services and children with serious emotional disturbances (SED) - *The number of children/youth served with a Substance Abuse diagnosis has increased from 4% (former Willie M. class members) to 13% for those eligible for CTSP*. A SubstanceAbuse specialist participates weekly in the State Collaborative and actively assists in incorporating of SA issues in planning/decisions. SA block grant funds were dedicated to the development of community-based treatment options for youth with substance use and abuse issues. Youth who have severe SED are the core target population for CTSP. Eligibility criteria is based upon the foundation of strengths and needs known for these youth, including functional impairment in health, home, school and community, and the need for cross-agency care. Cross training with DSS/Child Protective Services and substance abuse and mental health personnel working with children and families has occurred as a part of a federal substance abuse initiative initiative.

4.5 - Multidisciplinary Case Management – This service is vital to promoting continuity of quality care for children and youth and their families. The Child and Family Team structures help promote case management across agencies, i.e., all agencies that work with a child/youth and his/her family are expected to work together to build one Integrated Service Plan in which each party has a clear role and responsibility, including case management. Progress is being made here, though technical assistance and training is needed to reinforce this new, more comprehensive approach with existing personnel. In addition, a statewide network of qualified and trained network of case managers who can meet these intense complex levels of needs is not in place.

It should be noted that community providers are indicating a high turnover of case managers working in children's programs. This is of great concern to comprehensive implementation of the CTSP and sustaining continuity of care for eligible children and their families. Case management is an essential function funded through CTSP.

4.6 - A system of utilization review specific to the nature and design of the Program – Community Collaboratives are responsible for assessing and managing local resources, overseeing expenditures of CTSP service funds, and maintaining a Waiting List for any services unavailable for a given child/youth. Refer to Section 21.60.(g) for waiting list data. Child and Family Teams assess the needs for each child/youth, in partnership with the family to ensure comprehensive care. Adherence to Level of Care criteria is required for mental health services delivered through CFTs. To build seamlessness, Value Options, which provides Utilization Review (UR) for Medicaid services has incorporated the SOC model into their UR protocols. Further development of an UR system unique to the needs of the Program is underway through the State Plan. Refer also to Section 21.60.(g).

4.7 - Mechanisms to ensure that children are not placed in DSS custody to obtain MH treatment services – Technical assistance through Regional trainings for all involved agencies and through language in MOAs makes clear that unnecessary placement in DSS is not allowed. Regional staff from DSS and Child and Family Services Section work together with local Community Collaboratives and, if necessary, individual Child and Family Teams to eliminate unnecessary DSS custody. The State Collaborative has recommended a plan to allocate Social Services Block Grant funds as a flexible source of funds with specific requirements to divert unnecessary DSS custody. Due to the budget status this has not been possible. Refer to CTSP diversion outcomes of DSS custody in Section 21.60.(g).

4.8 - Mechanisms to maximize current State and local funds and to expand use of Medicaid funds to accomplish intent of Program – As noted in Objective 2 (b), services options have been increased with State funds. As noted previously, the State Collaborative has drafted a funding grid of all state and federal funding streams to assist local Community Collaboratives and CFTs in better understanding how to utilize all available funds to the maximum benefit of children, youth and their families. Results from the appropriateness reviews of individual service plans and cost reduction strategies

for services delivered can be found later in this report in Section 21.60.(b) Objective 1.3 and 1.4, Section 21.60.(c) and Section 21.60.(g).

4.9 - Other appropriate components to accomplish purpose – Training and technical assistance are crucial components necessary to facilitate system change and establish best practices in a comprehensive SOC. As noted previously, efforts are ongoing to provide the new skills and philosophical approach required developing a collaborative and comprehensive approach to care. Delivery of training and technical assistance has been a significant challenge given restrictions on travel due to the current State budget crisis. *In two different surveys documenting community needs, the needs assessment results ranked training in implementing a system of care as one of their highest needs*

4.10 - The Secretary of DHHS and contracts with residential providers – The development of a Request for Applications process for developing provider network capacity and new resources for 'special populations' (youth who are SED, Deaf/HOH, sexually aggressive) has resulted in awards to and pending contracts with residential provider based on availability of funds due to the State budget crisis. Refer to Section 21.60 (f) below.

4.11 - System to identify and track children in out of home placements – Plans to implement this new requirement are in development as a part of the state plan.

SECTION 21.60 (b)
21.60.(b) OBJECTIVE 1 – Ensure that target population is appropriately served by DHHS/DMH/DD/SAS

Progress in Meeting Objective:
1.1 - Medically necessary services – This is addressed above in Section 21.60.(a) and below. Appropriateness reviews as required in Section 21.60.(g) were conducted to assess that medically necessary criteria were met (100% in all cases reviewed).
1.2 - Utilization review (UR) – This is addressed in Section 21.60.(a) 4.6 and 4.8 above. Per legislation, DHHS, Division of MH/DD/SAS is responsible for implementing a system of utilization review of the services **specific** to the nature and design of the Comprehensive Treatment Services Treatment Program. In an effort to comply with this requirement, Area Programs were deemed responsible for creating and implementing a plan for utilization review for children deemed eligible for CTSP funds and submitting these plans to the Division of MH/DD/SAS, Program Accountability.

A review of the plans submitted by Area Programs revealed that the plans varied widely in nature and scope. While the plans submitted used the state Levels of Care developed for Medicaid reimbursable services as the basis for utilization review, many of the plans only referred to utilization review of Medicaid funds. Specific mechanisms for utilization review of CTSP funds were not included. Additionally, most plans did not recognize other funding streams such as Health Choice or private insurance and include a review process for these funds.

Plans varied widely on timing of reviews. While a majority of the reviews described a prospective review process, they did not include a retrospective review process. Conversely, some of the Area Programs submitted a plan that included a retrospective review process only. While some Area Programs referred to the Medicaid appeals process for Medicaid funds, a specific appeals or grievance process for CTSP funds was not included in the utilization review plan. There is not a clear link between the clinical programmatic (CFT/service plan) and administrative UR/UM process internal to the Area Program. This disconnect does not provide a clear process that supports initiating and sustaining clinically appropriate and necessary continuity of care.

In SFY03, it is recommended that a model UR plan be developed as a guide for Area Programs. In particular, appropriate delegation of decision-making for medical necessity must rest with the Area Program representative of the Child and Family Team and those decision must be made with the active involvement of all CFT members, along with clear delineation of the appeals process for CTSP funds and of the Division's expectation of the UR process (prospective vs. retrospective, UR vs. UM).

1.3 - Guiding principles for provision of services:

- A System of Care approach incorporates and requires adherence to the principles referenced in the legislation. The CTSP is being implemented through a statewide SOC approach, i.e., outcome-oriented, evaluation-based, and delivered as close as possible to home. Incorporation of all involved parties in one comprehensive Child and Family Team reduces duplication of services and fragmentation of delivery. Services delivered are those agreed upon by the CFT; those most appropriate to address the strengths and meet the needs of that child/youth/family, and do not include services provided solely for the convenience of the provider or child/youth.
- Family involvement - A core value of a SOC approach is the active involvement of families at all levels of service, program and system activities. As noted above, a parent of a child with SED co-chairs the State Collaborative and all Local Community Collaboratives require participation of family members to represent the interests of local families. Recent allocation of CTSP funding includes a mandatory dedication of a percentage of funds to support the involvement of families in the local SOC. Family members also actively participate in the weekly State Collaborative, along with advocates from MHA, NC AMI and others. A newly formed family advocacy network that involves families participating in NC AMI, MHA, and 'independent' advocacy groups (NC Families United) has emerged from the implementation of SOC grants funded by the Center for Mental Health Services (CMHS) and is highly active in supporting the implementation of statewide SOC. Families United recently acquired non-profit status and received a grant from CMHS to assist in statewide SOC implementation.

1.4 - Cost reduction strategies – As noted previously, Child and Family Teams plan all services delivered, Area Programs provide Utilization Review, and Local Community Collaboratives manage utilization at the local aggregate level. The Child Levels of Care document is utilized for all medical necessity determinations and utilization review guidance within the Child and Family Team for Medicaid and non-Medicaid services.

- The following were some findings documenting positive outcomes in applying cost-reduction strategies in the implementation of CTSP in the appropriateness reviews conducted in February 2002 per Section 21.60.(g):
    - Children who had the most expensive services tended to be those with more complex diagnoses that were often compounded by co-occurring problems that were more deeply entrenched in childhood and requiring a multiple system response.
    - There were instances where children who had the most expensive services could have been served in less restrictive environments except that these children were without a family and did not have options other than residential care. . With an appropriate array of interagency services and informal supports, these youth could be served in the community.

    - Diversions occurred in 42 percent of the cases. Approximately 16 percent (58) were diverted from training schools; 11 percent (40) from State Psychiatric institutions, and 7 percent (24) from DSS custody.
    - A reduction in program expenditures occurred for children who had high utilization rates. The number of children with annual costs of $100,000 and more reduced from 225 in fiscal year 1998-1999 to 102 in fiscal year 2000-2001. The number of children with annual costs of $75,000-99,999 similarly declined from 202 in fiscal year 1998-1999 to 74 in fiscal year 2000-2001.
    - All but one of the children who had treatment expenditures in excess of $75,000 were Medicaid eligible. While Medicaid covered approximately 20% of treatment costs, to ensure appropriate services, state funds were needed to cover 80% of total treatment costs.

- Of children served, 77% are Medicaid eligible, according to September 2001 data.
- In addition, refer to Section 21.60.(a) 4.8.
- State review of individualized service plans – Regional Service Managers in the Child and Family Services Section completed appropriateness reviews as required by Section 21.60.(g). Some of the results are reported above and in the sections following. Plans for implementation of a Community-Based Practice Review Process carried out through cross-agency state, regional, community provider staff and others are in development. This process would provide necessary baseline measures for indicating outcomes resulting from the implementation of this Program and has been recommended as part of the state plan implementation.

SECTION 21.60.(c)

21.60.(c) OBJECTIVE 1 – DHHS shall collaborate with other affected State agencies to eliminate cost shifting, and facilitate cost sharing with respect to treatment and placement services.

Progress in Meeting Objective:

1.1. - This is addressed in Section 21.60.(a) and (b) above.

- Of children served, 77% are Medicaid eligible, according to September 2001 data.

- Diversions occurred in 42 percent of the cases. Approximately 16 percent (58) were diverted from training schools; 11 percent (40) from State Psychiatric institutions, and 7 percent (24) from DSS custody.
- In addition, it should be noted that improved child outcomes for school achievement have been documented in those children who have been supported through a system of care approach using a child and family team and collaborative supports. In addition, a primary factor linked with these outcomes is directly related to those children and families that have access to family support organizations in their communities.

SECTION 21.60.(d)

21.60.(d) OBJECTIVE 1 – Allocation of funds and MOA between DHHS, DPI, and other affected State agencies

Progress in Meeting Objective

1.1 - MOAs were established in SFY 2000-2001 and were re-signed by all parties by June 30, 2001 for SFY 01-02. These were established as required by the 'At Risk' special provision (HB1840).

- Currently there are two Local MOAs in place as a result of the 'At Risk' special provision:
  - DSS/Area Mental Health MOA: This MOA *is not* in response to last year's legislation regarding At Risk Children. It was in process for over a year prior to the "At Risk" legislation. It addresses timely access to mental health assessments and includes definitions of Clinical Case Management and At Risk Case Management, as well as definitions of Emergency, Urgent, and Routine Care regarding Mental Health Assessments. The definitions of Case Management outlines in this MOA have been incorporated as revised draft Medicaid service definitions. The local Director of the Department of Social Services and the local Area Director of the Mental Health Center sign this agreement.
  - DJJDP/Area Mental Health MOA: This MOA *is* in response to last year's legislation regarding At Risk Children. It specifically addresses Residential Services to At Risk Children in Need of Mental Health or Substance Abuse Treatment. The MOA includes (a) requirements of the legislation, (b) responsibilities of DJJDP & Area Authorities regarding screening, assessment, and treatment of youth who are in need of residential and mental health/substance abuse treatment, and (c) definitions of the Child and Family Team, and the local Community Collaborative. The Division of MH/DD/SAS does not collect this MOA, however it is kept at the local level. It is required to be signed as outlined in last year's legislation (HB 1840), and is monitored by the Program Accountability Section, DMHDDSAS during annual program audits.

1.2 - The State Collaborative is currently developing one integrated MOA between all affected State agencies, including, but not limited to DHHS, DPI, DJJDP, AOC and local DSS, DPH, Area Programs and Local Education Agencies. All requirements specified in this Section are addressed in the revised MOA Draft for SFY03.

- MOA drafting committee began meeting 10/19/01. Participants included representatives from DJJDP, AOC, DPI, DHHS

- The draft MOA includes (a) the legislative requirements, (b) the guiding principles, (c) the four functions that all four departments agree to accomplish, and (d) the specific responsibilities that each department agrees to implement.
- Currently, the draft has been disseminated to the four departments and is in the process of being reviewed by division and department staff.
- The local level MOA will be drafted after the State MOA is finalized.
    - The Administrative Office of the Court (AOC) has actively engaged as a partner in implementation of the State MOA:
        - The unified Family (District) Court model being implemented in NC is a collaborative model, designed to encourage continuing coordination and collaboration between the Family Court and local service and treatment agencies. So all matters affecting a family, whether a juvenile delinquency case or a neglect/abuse case, or a child custody case, are heard by one judge, and all treatment efforts for that family are coordinated by the Family Court staff. Therefore Family Court staff should actively participate in the Child and Family teams.
            - The AOC continues to pursue funding for a fully automated case tracking and management system that would connect court records with data from other agencies.
            - Beginning with the June 2002 District Court Judges Conference, training on the System of Care will be regularly offered to all judges. The eight Family Court Administrators were trained on SOC this past November.
            - In addition, AOC staff will continue to participate as members of the State Collaborative to develop policies and procedures to address the needs of children under the Comprehensive Treatment Services Program.
        - A "Youth Treatment Court (YTC) team" is composed of: a specially-trained District Court Judge, District Attorney or Assistant District Attorney, a Juvenile Defense Attorney, a YTC Case Manager/Coordinator, a Juvenile Court Counselor, a representative of the local school system, and one or more representatives of the youth and family treatment community
            - The team often includes a representative of local law enforcement (juvenile detective, community police or school resource officer), a representative from the Health Department, a representative from the Department of Social Services, and others including representatives from youth/family serving agencies and programs or other community programs/faith communities.
                - Youth Treatment Court Case Managers/Coordinators will begin to collect data in March 2002 for all YTC clients concerning number of Child and Family Team Meetings conducted, number of youth referred for a behavioral health screening, number of youth found eligible for CTSP funds and number of youth who have accessed CTSP funds.
                - All Youth and Family Treatment Court teams (7 teams) will receive training in system of care, strengths-based assessments, case plan development and implementation in March 2002 and will continue to receive support and ongoing training concerning system of care best practices.

- Funding has been sought for a management information system (MIS) for Youth Treatment Court that will be compatible with the pending DJJDP MIS.

SECTION 21.60.(e)

21.60.(e) OBJECTIVE 1 – Services under CTSP are not an entitlement

Progress in Meeting Objective:

1.1 - All training and correspondence relevant to this topic has emphasized that services are no longer an entitlement.

SECTION 21.60.(f)

21.60.(f) OBJECTIVE 1 - DHHS shall establish a 3% reserve of CTSP funds for specialized needs for children with unique or highly complex problems.

Progress in Meeting Objective:

1.1 – The DMH/DD/SAS held in reserve 3 % of total funds ($1,560,065).

1.2 - The State Collaborative designed and implemented a Request for Applications (RFA) process to develop new resources identified as most needed for these children with complex needs, based on a survey of Regional Collaboratives and according to the priority populations in this Special Provision. The RFA was publicized in early October 2001, a Bidder's Conference was held. Targeted service development included non-residential and residential alternatives designed to divert youth from institutionalization and DSS custody including services for youth who with SED and who are deaf and/or sexually aggressive as outlined in legislation. Over 50 applicants attended the Bidder's Conference from across the State, with most representing private providers. Eighteen (18) applications were received. An ad hoc subcommittee of the State Collaborative reviewed all applications. A total of nine (9) provider applicants were awarded funding as a result of this process. Funds from the 3% reserve are being utilized for one-time 'start-up' implementation of these new resources, with a required sustainability budget maximizing local and state funds required of all applicants.

SECTION II - DESCRIPTIVE PROGRAM DATA OF CHILDREN AND FAMILIES SERVED

This section describes the children in the Comprehensive Treatment Services Program (CTSP). Reported below is specific information on:

- the number of children referred as eligible and served,
- children on the waiting list for CTSP,
- the demographic characteristics of children in CTSP, and
- the service provision characteristics.

SECTION 21.60.(g)

21.60.(g) OBJECTIVE 1 – DHHS, DJJDP, DPI and other affected agencies report on the following:

Progress in Meeting Objective:

1.1 - Number of children/youth served and demographic information – The number of children served in the Comprehensive Treatment Services Program grew steadily in calendar year (CY) 2001.

- *More than 3500 children have now been served in the Program*, more than twice as many as were identified and served through former Willie M entitlement funding.
- Referrals to the program and eligibility determinations are at much higher levels than they ever were since the inception of the Special Populations (Willie M) Program. In 1999, 533 children were screened and 373 were found to be eligible for the Program. *In CY 2001, a total of 2,499 were screened, 2, 170 of whom were found to be eligible.* This represents *more than a 400% increase in those children identified as eligible and served through CTSP*.
- The number found to be eligible in CY 2001 alone is more than twice (216% increase) that of the cumulative total of 1, 660 children found to be eligible and served in CY 1999. The total number of children/youth served in FY 2000-2001 was 2, 941.
- Of children served, 77% are Medicaid eligible, according to September 2001 data.
- The demographic characteristics of the children served are outlined below.

    - Race or Ethnicity - The racial or ethnic distribution of children served in the Program has remained consistent over time. Whites comprise 57 percent of the target population while African Americans making up 39 percent, a representation that is 10 percent more than the proportion found in the general population. One percent is Latino in ethnic origin. Refer to Chart 1 below.

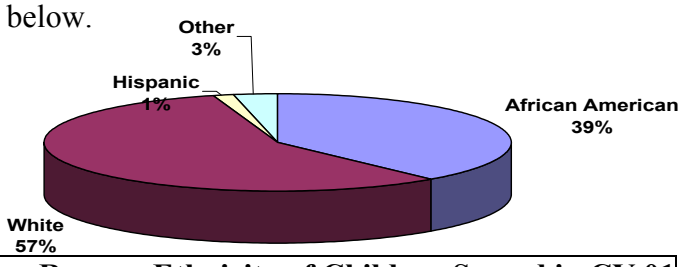


Chart 1 - Race or Ethnicity of Children Served in CY 01

- Gender - The children in the Program are predominantly male, making up three quarters of the total number served in 2001. Refer to Chart 2 below.

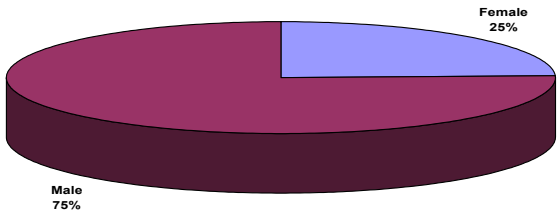
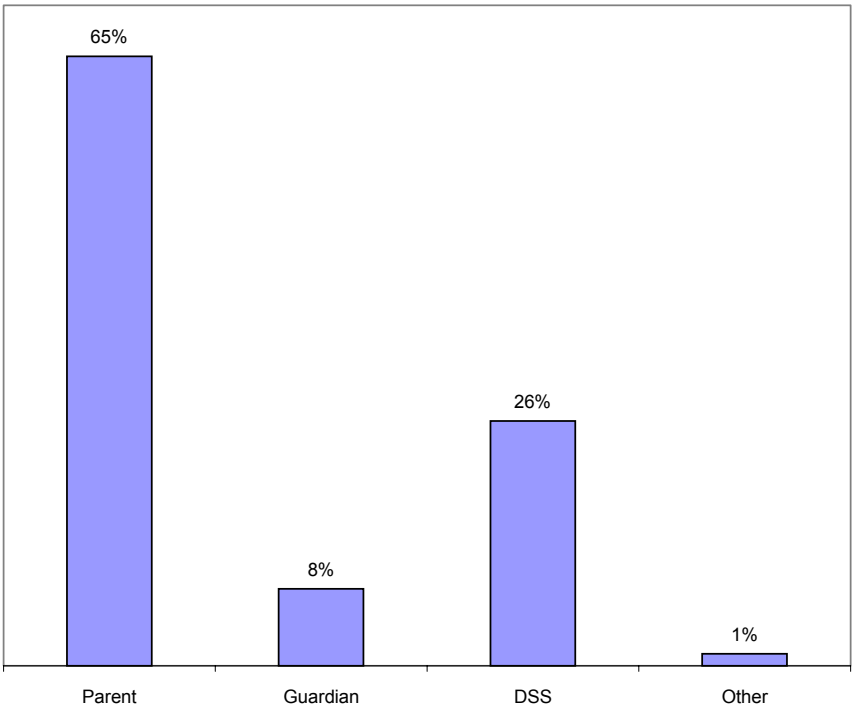


Chart 2 – Gender of Children Served in CY 01

- Guardian - Most (65 %) of the children in the Program were in the custody of a biological parent who was typically the mother. Approximately one- fourth (26 %) was under the guardianship of the Department of Social Services. Refer to Graph 1 below.



Graph 1 – Guardian Status of Children Served in CY 01

1.2 - Amount and source of funds – Total service expenditures for SFY 2000-2001 were $78,803,778 ($25,313,553 Medicaid and $53,490,225 At Risk/Residential Treatment State funds). Though sought through the State Collaborative partners, additional sources of service funding for CTSP eligible children were not available for Health Choice or from DSS, DJJDP or DPI. Funding for CTSP services is currently not tracked in agencies external to DMH/DD/SAS.

1.3 a) - Number of children screened – In SFY 01, 3,438 children and youth were screened, 3,172 of whom were determined to be eligible for the Comprehensive Treatment Services Program. In CY2001, 2,499 were screened, 2,170 of whom were found to be eligible.

b) The number of children waiting for services – As part of their Performance Agreements, Area Programs were required to submit quarterly information on each and *every eligible (CTSP) child* waiting for services at any interval. In the first two quarters of SFY 02, 141 children were on the waitlist of 13 Area Programs. Highest on the list of services that these children were waiting for were residential services of all types, cited for 102 (72%) of waitlisted children. Around 57 percent (81) were waiting for the higher levels (Level III –high and Level IV – secure) of residential treatment facilities. Close to one-third 31 %; 43 children) were waiting for the more clinically intense type of treatment at Psychiatric Residential Treatment Facilities. Relatively high proportions (20%) were waiting for outpatient services (20) and case management (19).

By December 31, 2001, there were only 53 children *eligible for CTSP funding* were on the waitlist. Twenty-two (22) were youth who had problems with sexual aggression, one of whom was hard of hearing as well; four had developmental disabilities, and; three had substance abuse problems. A total of 21 waitlisted children, including 14 who had problems with sexual aggression, were waiting for Levels III and IV residential services.

Fourteen (14) were waiting for intensive case management; seven (7), for treatment at psychiatric treatment facilities, and seven (7) for partial hospitalization. Other services cited were respite (2), day treatment (2), specialized foster care (2), and community based services in school (1). One (1) was waiting for out-of-state residential treatment. ***NOTE:*** *Those children on this waiting list are those eligible for CTSP for whom services needed were not available. This list does not capture needs of all children waiting for mental health services in the state.*

- **Appropriateness and medically necessary services** -To determine whether services were appropriate and medically necessary, case reviews were conducted of all children currently served in CTSP who were formerly designated as Willie M prior to January 1998 as well as those whose annual costs for services exceeded $100,000. Experienced regional case managers reviewed 367 cases between January 18 and February 21, 2002. Fifty-two of the cases reviewed had costs that exceeded $100,000 per year.

Service plans were found in the files for all but two percent (8) and were monitored by a case manager in all but three percent (11) of the cases. Most (7) of the latter had no case managers because they were in training schools. Service plans had been rewritten or updated as recently as six months ago or less for half. of the cases reviewed. The plans addressed psychological or emotional, social, educational, family, residential, and medical needs in 70 percent or more of the cases. Needs that were addressed less often were safety (32%) and legal (29%) needs.

Services were considered to be appropriate in 78 percent of the cases reviewed. The more general reasons for determining services to be inappropriate were (a) refusal of or noncompliance with services by the child or caregiver (10) (b) child was in a training school (7) or in detention facilities (7); (c) need of Level III or IV out-of-home placement or PRTF or partial hospitalization (10), and need of community-based services (6).

1.3 b) - Specific placement of children –

- Refer to **Table 1** below for specific **living situations** of children served.
  - *Forty-one percent (41 %) have been able to remain living at home with utilization of the current array of nonresidential services*: case management, case management support, community-based services (CBS), outpatient, respite services.

Table 1 - Living Situation

At Home	41 %
Foster/Therapeutic Home	13 %
Group Home	16 %
Small group staffed	4 %
Non secure residential treatment center	4 %
Secure residential treatment center	2 %
Hospital	7 %
Independent living situation	2 %
Training School	2 %
Detention facility	3 %
Other	6 %

- The **number of children eligible for CTSP in DSS custody decreased** from 10,849 in July 1, 2000 to 10,255 in July 1, 2001. The number of children entering DSS custody for the first time similarly decreased from 5164 in State Fiscal Year 1999-2000 to 4855 in State Fiscal Year 2000-2001.
- While residential and non-residential capacity to serve children in the communities was being developed, an Out of State Protocol was established through the Child and Family Services Section and Program Accountability in DMH/DD/SAS with consultation from DMA that requires extensive documentation regarding the need for out of state placement and evidence that there are no resources in North Carolina that can appropriately meet the needs of the child or youth. All plans require a transition plan back to NC and step down

into lower levels of care. Most of the children in need of psychiatric hospitalization were placed in North Carolina settings. Twenty-one children are being served out of state due to complex medical and mental health needs. Most of these placements are in locations closer to their homes.

- Refer to **Table 2** below for specific **residential placement information**.

- **1.4 -Average LOS in residential treatment** – See Table 2 below.

Table 2
Average Length of Stay (LOS) in Residential Treatment

Service Description – Residential Treatment	ALOS in Days
FAMILY TYPE RESID TX LEVEL I	61.8
FAMILY TYPE RESID TX LEVEL II	109.0
PROGRAM TYPE RESID LEVEL II	82.9
GROUP HOME – MODERATE NON-MED	96.3
PROGRAM TYPE RESID LEVEL III	119.2
RESIDENT TX SECURE LEVEL IV	53.7
GROUP LIVING – SPECIALIZED	87.2
RESIDENT TX LEVEL III-1-4 BEDS	46.2
RESIDENT TX LEVEL III-5+ BEDS	41.0
RESIDENT TX LEVEL IV-5+BEDS	40.0
RECREATIONAL CAMP OVERNIGHT	14.5
PSYCHIATRIC HOSPITALIZAITON	41.4

Note: Tx – Treatment; Level I to IV is least to most restrictive

1.5 - Number of children diverted from institutions or other out of home placement, training schools, and state hospitals – Service Appropriateness Reviews showed that *diversions occurred in 42 percent of the cases. Approximately 16 percent (58) were diverted from training schools; 11 percent (40) from State Psychiatric institutions, and (7 percent (24) from DSS custody.*

1.6 and 1.7 -
Recommendations on other areas of the Program that need to be improved and other relevant information for successful implementation of the Program according to the State Collaborative:

- **Develop and Deliver Technical Assistance and Training in a systematic fashion to all 100 counties and Support for State and Local agency staff to participate.**
  One of the biggest barriers to effective statewide implementation has been the restriction on travel and training expenditures due to budget restraints and central office staff reductions. While progress has been despite these barriers, intensive on-going training at the direct service level is necessary to achieve practice changes that promote collaboration across service delivery systems and treatment of families as full participants. Training is also needed

for members of local Community Collaboratives and for Regional Staff of affected state agencies. The nationally recognized outcomes resulting from implementation of North Carolina's three Center for Mental Health Services grants could not have been achieved without intensive training and technical assistance. *In two different surveys documenting community needs, the needs assessment results ranked training in implementing a system of care as one of their highest needs*

- **Study the Integration of Collaborative Efforts Across Child-Serving Systems into a Single Collaborative Structure at the Local Level.** Currently there are many requirements for local agency staff to attend multiple collaborative meetings to meet separate funding and programmatic mandates. The goal of this study would seek to improve efficiency, reduce duplication of effort and expense and increase the incentives of agencies to collaborate. The study would require reviewing various child-serving initiatives that require participation in formal interagency coordination and collaboration and those local working models of community-based integration and develop recommendations for addressing functions necessary to improve utilization of scarce resources, ultimately improving child and family outcomes.

- **Study Legal Mechanisms to Reduce the Liability of Non-Governmental Partners in the Community Collaborative Activities.**
  Family members/caretakers' and private providers full and active participation in local Community Collaboratives is essential to improving the outcomes of children eligible for CTSP as a part of a System of Care approach. The Community Collaborative is the vehicle through which services are managed, decisions made regarding funding and implementation of the local SOC. A potential barrier to the Collaborative's ability to function is the role and legal liability that family members and other non-governmental participants face in the local Community Collaborative. Further study of this issue is needed to determine appropriate protections to be put into place to ensure meaningful family and community involvement in this time of limited resources.

- **Establish Statewide Implementation of Service Testing as a means for Tracking Service Systems' Outcomes over Time**
  The systems' accountability infrastructure is currently shifting from the narrow Willie M. tracking system to a broader systems change analytical framework. Efforts are underway to integrate budgeting, outcome and data reporting into a streamlined structure that can evaluate SOC implementation in a way that is consistent with best practice national evaluation efforts (e.g. the National Evaluation required by Congress of all CMHS grantees). Attuned focus on the establishment of a comprehensive methodology to assess SOC systems change is necessary as the state reform plan implementation takes place. Service Testing is a nationally recognized method to assess baseline cross-agency service delivery progress and track service outcomes over time. This strategy is currently operational in only 22 counties (i.e. the SOC demonstration grant sites). The Division is reviewing a plan for an incremental statewide implementation of this tracking methodology in order to meet implementation timeframes in the state reform plan.

- **Examine impact of granting Legislative Authority to State Collaborative Representatives to act as Decision-makers for their individual Child-Serving Systems. This review will also examine the need for the establishment of staff expectations within their System to Fully Support the Collaborative Model as the New System Adapts and Matures.**
  A current challenge is the developmental nature of moving from a narrow categorical service system, Willie M., with virtually unlimited resources, to a comprehensive and collaborative service system for a much broader range of children/youth in need of mental health treatment services. Resources are limited and will take time to develop. Collaboration among agencies and with families also develops incrementally. Consistent messages 'from the top' to all child-serving agency staff are critical to the successful establishment of a comprehensive and collaborative service system. *The State Collaborative is currently the entity that is best situated to provide the direction necessary to help the new service system reaches its full maturity. The study shall review other existing "collaboratives" and liability before making final recommendations.*

- **Convert 20% of UCR funding to non-UCR funding to provide for more Start-Up and Capacity-Building of System of Care Services as Proposed in the State Plan for FY 2003.**
  In order for Child and Family Teams to be effective in helping families to keep their children safe and well in their homes and/or communities, every community must have a basic floor of mental health services that is outlined in the Secretary's State Plan. For example, the availability of even a limited pool of flexible funding would enable Child and Family Teams to implement wraparound approaches for individual children that would decrease the need for more high-end services and thus decrease anticipated service costs. Converting UCR funding into non-UCR funding that can be allocated to each community specifically for the purpose of resource development in accordance with State Plan goals and local community needs assessment and decision-making would be a critical strategy in diverting unnecessary out-of-home placements and the accompanying massive expenditures. In addition to specific service development, non-UCR funding should be allocated to each Area Program for the purpose of hiring a SOC training and technical assistance person who could provide the training and technical assistance at both the practice and systems level to support the implementation and development of the CTSP. *In two different surveys documenting community needs, the needs assessment results ranked training in implementing a system of care as one of their highest needs*

Strengthen the existing Memorandum of Agreement by requiring the Mandated Agency Partners to Provide Data and Participate in the Monitoring of the Outcomes Delineated for the Comprehensive Treatment Services Program.

- **Develop a model UR plan.** Currently Area Programs are implementing utilization review requirements in a number of different ways across North Carolina. Data from some of the Area Programs indicates that Utilization Review is occurring as a separate process outside of the Child and Family Team decision-making. Such implementation undermines the role of the Child and Family Team in the service delivery planning process and is a violation of the System of Care model approach known to be effective in achieving positive outcomes.. A

model utilization review plan that is both consistent with the System of Care principles and philosophy and will ensure that the appropriate level of care is authorized each child can be developed and provided as a guide for all Area Programs. Elements to consider as part of a model Utilization Review plan should reflect System of Care principles, including a description of the interface with medical necessity, clinical appropriateness, flex funding and wraparound planning, a description of Child & Family Team and the Community Collaborative roles in the utilization review process, a flow chart indicating timing of notification of utilization review decisions to these two groups should be developed, a description of how all potential funding sources, including Medicaid; CTSP, Health Choice, and private insurance are considered when conducting utilization review. In addition, links from the UR plan to the quality improvement process and a clear delineation of the appeals process for CTSP funds should be addressed.

- **Release allocation letters and other procedural guidance-**related to accessing CTSP UCR and non-UCR funds within 30 days of the final approval of the State budgetto ensure timely and effective expenditure of funds for implementation of CTSP.

- **Child and Family Teams for families with court-involvement should include Family Court workers in the service planning process.** The unified Family Court model being implemented in NC is a collaborative model, designed to encourage continuing coordination and collaboration between the Family Court and local service and treatment agencies. All matters affecting a family, whether a juvenile delinquency case or a neglect/abuse case, or a child custody case, are heard by one judge, and all treatment efforts for that family are coordinated by the Family Court staff. Therefore Family Court staff should actively participate in the Child and Family teams. All Youth and Family Treatment Court teams (Wake JDTC, Durham YTC, Durham FTC, Mecklenburg JDTC, Mecklenburg FTC, Rowan JDTC and Forsyth YTC) will receive training in system of care, strengths-based assessments, case plan development and implementation in March 2002 and will continue to receive support and ongoing training concerning system of care best practices. Funding has been sought for a management information system (MIS) for Youth Treatment Court that will be compatible with the pending DJJDP MIS.

- **All Mandated Agencies should continue to Participate on the State Collaborative** to ensure that policies and procedures to meet the needs of all children who enter the comprehensive treatment program are developed.

- **Broaden the Network of Providers that receive System of Care Development Training to include a wide variety of Private Providers who are active in communities throughout North Carolina.** A number of children receive mental health services from private providers. Primary care physicians are sometimes the first points of contact for children with mental health problems; these providers can offer services and referral to other community providers. In addition to primary care providers or publicly-funded providers, children and adolescents receive mental health services from psychiatrists, psychologists, certified or licensed clinical social workers, certified clinical specialists in psychiatric and mental health nursing, certified substance abuse counselors, or certified clinical addiction specialists working in private practice. The state lacks data on the number of children served

by primary care providers or other health professionals in private settings. Lasting positive outcomes for children, youth and families will only occur when public and private providers work together and adhere to best practice approaches.

- **DPI staff will continue to work with State Collaborative members to identify funding that can be used in conjunction with CTSP funding to help families meet a range of mental health needs.** Two DPI staff will continue participate regularly in the monthly State Collaborative meeting and are members of working committees. Several DPI funding streams that could be used to support the educational needs of children who are eligible for CTSP have already been identified. The next step might be develop training and technical assistance materials that can be provided at the community level to make Child and Family Teams and Community Collaboratives aware of these resources and knowledgeable about how to access the appropriate funds to meet the specific needs of the identified children.

- **Implement Positive Behavior Integration Strategies (PBIS)** at minimum, in all Alternative Schools through interagency agreement partners including DPI, DMH/DD/SAS, DPH and Primary Care providers will continue to help school personnel and families meet a range of mental health and substance abuse needs for the most at risk youth eligible for CTSP in the LEA communities. Significant findings from national studies and NC DPI experience in implementing federal school improvement grants focusing on strengths-based access to services and supports to youth in school settings are congruent to national and state SOC outcomes achieved and indicate substantial findings in prevention and mediation children and youth needs.

- **Require Implementation of A Common Behavioral Health Screening** as a part of a consistent comprehensive developmental screening and assessment protocol to improve child find within the broader informal and formal provider network.

• SUMMARY of KEY FINDINGS

While with any system change, there are elements that evolve over time to gain the desired outcome; the successful implementation of CTSP to date has improved:

- Access to earlier identification through behavioral health screening of children across agencies.
- Access to residential and non-residential community based services.
- Increased commitment and shared responsibility to serving the most vulnerable children (those in need of mental health and related services and supports)and their families.
- Quality of and continuity of care through the implementation of a consistent system of care approach at the state, regional and community levels.
- Quality of care through the intentional involvement of families and youth, when possible, through strengths-based treatment planning.
- Efficiencies in cost reduction and coordination of care for children with complex treatment needs.
- System reform through effective mechanisms for providing care, utilization review, outcomes based quality improvement and technical assistance.